

To: Alabama Board of Medical Examiners

QACSC Covering Physician Agreement

As a covering (back-up) physician providing medical direction and oversight for _____, CRNP / CNM, by signing this document, I hereby affirm that:

- (1) I am familiar with the current rules regarding certified registered nurse practitioners and / or certified nurse midwives and their ability to prescribe controlled substances.
- (2) That I am familiar with the Approved Formulary for Qualified Alabama Controlled Substances Certificate concerning CP# _____ and with all protocols and medical regimens relating to a QACSC which have been adopted by the Board of Medical Examiners.
- (3) That I have a current and unrestricted Alabama Controlled Substance Certificate, # _____.
- (4) That I will be accountable for adequately providing medical direction and oversight for the prescribing of controlled substances by the certified registered nurse practitioner or certified nurse midwife.
- (5) I will assume all responsibility for the controlled substance prescribing of the certified registered nurse practitioner or certified nurse midwife during the temporary absence of the primary Collaborating physician.

Telephone number _____ Fax number _____

Relationship with primary Collaborating Physician: (check one below)

Partnership _____ Professional group _____ Medical Professional Corporation _____

Physician Practice Foundation _____ Physician sharing call _____

Medical Specialty of Collaborating Physician _____

Medical Specialty of Covering Physician _____

Print Physician Name

Lic #

Physician Signature

Date